Understanding organizational culture in reforming the National Health Service

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J R Soc Med 2002;**95**:140–142 QUALITY IN HEALTHCARE FORUM, NOVEMBER 2001

If 'education, education, education' was the mantra of the incoming Labour government in 1997, 'delivery, delivery, delivery' has been the refrain from 2001. Reforming and modernizing the NHS to deliver the scale and quality of health services required for a demanding 21st century public has been one of Labour's biggest policy pledges. It remains perhaps its most serious challenge in its second term of office. Failure here will both seriously undermine the New Labour project and inflict serious damage on the arguments for publicly financed, publicly provided, health services with universal access.

Achievement of a modernized health service and radical improvements in delivery are seen to require more than just the planned large cash injection: they also require health system reform. Major reforms of the health systems of developed nations over the past two decades have been largely structural in content. Through the 1970s and 1980s, changes to the hierarchical arrangements of the NHS presaged more radical plans for a rearrangement of players into purchasers and providers and the introduction of the internal market. This reaching for competition—created by structural rearrangement—mirrored upheavals in healthcare elsewhere in the world. Various combinations of managed competition and managed care have been tried and are evolving in the USA, Australia, New Zealand and many parts of Europe.

In opposition, Labour decried the internal market. Once in power they kept many of its structural elements (the crucial separation between operational and strategic responsibilities) while updating the rhetoric (eschewing the language of competition, embracing instead cooperation and partnerships). Their major reform effort focused on quality issues[1], developing a plethora of agencies such as the National Institute for Clinical Excellence, the Commission for Health Improvement, the National Clinical Assessment Authority, and the Modernization Agency. The latest round of NHS reforms ('Shifting the Balance'[2]) again emphasizes structural changes as a means of driving improvements in delivery.

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PLUS ÇA CHANGE...

Yet what emerges from evaluations of large-scale structural reforms is how little they impact below surface manifestations[3]. Organizational structures are changed, new names and job titles emerge, the rhetoric and jargon adapt to new expectations, but service realities often remain stubbornly resistant to change. The central paradox then is why, with more cash and radical reorganization, does so little change? Those interested in 'complex systems' have no difficulty in understanding the lack of responsiveness: they see such 'non-linearity' (large stimulus, small response) as integral to systems as complex as the NHS[4]. However, another way of unravelling the paradox is to ask a different question: what are the structures that matter the most—those formal and explicit structures of organization charts, accountability relationships and contracts? Or the psychological and social structuring that govern how we think, what we value, and what we see as legitimate? Much of health system reform has tackled the former, while much that impedes change is concerned with the latter. These informal structures within an organization—sometimes referred to as 'the software of the mind'[5]—can be thought of as its 'culture'.

ORGANIZATIONAL CULTURE

To talk of an organization's culture is to assess that which is shared by individuals within the organization—their beliefs, values, attitudes, and norms of behaviour, for example; or the established routines, traditions, ceremonies and reward systems[6]. Organizational culture encompasses the shared meanings that individuals place on their working life, the narratives they use in making sense of their organizational context. The ways in which people understand, describe and make sense of their working context in turn help to define what is legitimate and acceptable in that context; they act as a kind of social and normative glue. They are 'the way things are done around here'.

Such shared understandings may operate at different levels. The most superficial are the visible manifestations (sometimes called cultural artefacts)—the doctor's white coat; the surgeon's list; the use of professional titles, and the commonly accepted reward structures. At a deeper level are those espoused values that are said to influence standard practice—a belief in evidence, for example, or a

commitment to patient-centred care. Deeper still, and much harder to access, are the hidden assumptions that underpin day-to-day choices—assumptions, for example, about the relative roles of doctors and nurses, assumptions about patients' rights, or assumptions about the nature and sources of ill-health. While we would expect some relationships between these assumptions, espoused values and visible manifestations, such relationships will not be simple; incoherence, self-deception and dissonance are more likely. What is clear however is that much of health systems reform tackles surface rather than deeper cultural issues.

Organizational culture as a metaphor for understanding organizations emerges from social anthropology and has been much written about by social scientists[6]. From their publications can be discerned two distinct ways of seeing organizational culture—as an attribute that organizations possess; and simply as a rich description of organizational life. Either approach may be useful in understanding both system performance and resistance to change.

An organizational attribute

The view that organizations *have* cultures suggests that there are aspects of the shared assumptions, beliefs and values held within an organization that can be isolated, described and even measured. Such a view may go further, suggesting that specific cultural attributes of an organization may be responsible for that organization's performance. For example, shared beliefs and attitudes about quality, risk and the role of patients in decision-making may be expected to influence service delivery. Thus the 1990s saw considerable credence attached to notions of changing the culture as a means of enhancing organizational performance—clinical governance, in current parlance. This view that culture determines performance was popularized in the 1980s by management gurus[7,8], but in truth there is only limited evidence in support[9].

A rich description

What of the concept of organizational culture as a 'rich description'? In part a reaction and critique of such modernist conceptions as that outlined above, this draws on post-modernist ideas about the indeterminacy of many organizational phenomena. In this view, organizations do not possess cultures as some kind of attribute, instead they simply *are* cultures in their own right. Such a view emphasizes the dynamic and unstable processes by which people make sense of their world, highlights the continuance of multiple and conflicting perspectives, and points towards the important role of power in defining legitimacy. This stance is thus sceptical of the idea that culture is a variable that can be manipulated to bring about desired effects, and seeks instead insights from rich descriptions of organizational life (while accepting that such insights are always fragile and contingent).

Both these conceptualizations of organizational culture may offer valuable insights and inform either research activity or an organizational analysis. Alternatively, one may attempt to steer a middle path, seeing culture as an emergent property of an organization—not fully predictable in substance or impact and with limited controllability, and yet describable and assessable in terms of the organization's goals, and, if not controllable, influenceable at least. After all, if maladroit leaders can sour an institutional culture, why should more positive influences be out of reach?

THAT WHICH IS SHARED

To many who work in the intensely tribal NHS, the idea of cultures *shared* across the organization may seem a bit of a stretch. Yet on examination there may well be values and beliefs that are wide and deep across the organization—even if some of these are negative, such as cynicism about change. At the same time, there will be stronger sets of more coherent cultures that are more readily seen within subgroups of the organization. Most obvious among these are the subgroups of the various medical subspecialties, nursing and the therapeutic professions. Each of these subgroups has dominant cultural values infused during education and training and maintained by influence from outside the employing organization (for example, by professional bodies such as the Royal Colleges). We may also see coherent cultures within specific teams where they can be a powerful influence on work patterns.

Any analysis of organizational culture will therefore need to identify and assess the dominant subcultures, their influences and their interactions. Some of these subcultures enhance and amplify the dominant culture in helpful ways (e.g. successful multidisciplinary teams; centres of excellence), whereas others may merely tolerate the

Box 1 **Unpacking culture in the NHS**

- Does the NHS have a culture? How does this differ within and between organizations, and within and between different subunits of those organizations?
- What are the core subcultures with which we have to work?
- What aspects of culture should be enhanced? What aspects diminished?
- What are the relationships between assumptions, espoused values and cultural artefacts?
- What are the relationships between aspects of culture and aspects of healthcare quality and organizational performance?
- How can cultural aspects be either supported or challenged?
- How will NHS strategy, structures and processes facilitate or impede cultural change?
- What is the role of leadership in defining both cultural destinations and means of transportation?

organizational culture but draw many of their values and beliefs from outside (e.g. medical subspecialties). In times of change one should also expect to see evidence of countercultures—where groups work overtly or covertly to challenge and undermine the dominant organizational culture. Such a pattern of resistance was evident during the structural reforms of the 1980s and early 1990s[10].

THE RISE OF CULTURE IN HEALTH REFORM

Despite the emphasis on structural change, culture has not been ignored in health system reforms. Indeed, recent years have seen culture—and the need for changes in culture—highlighted in official policy documents such as *A First Class Service*[11], and the implementation proposals following 'The NHS Plan'[2]. These talk of cultures of excellence, no-blame cultures, high trust, and learning cultures as desirable destinations for a reformed NHS. What is more, various types of 'bad' cultures—blame culture, macho culture, culture of secrecy—are regularly hung out as the villains of the piece when enquiries get to grips with organizational failures. The most notorious of these villains was the 'club culture' highlighted in the Kennedy Report on Bristol[12]. However, what the foregoing discussions should highlight, if nothing else, is the need to be more explicit about what we mean by cultures before declaring that therein lie the roots of organizational success or failure.

CULTURAL ANALYSIS ALONGSIDE STRUCTURAL REFORM

Large-scale structural reform may be important because structures set the context within which people work and they communicate important messages about what is important. In turn, organizational cultures help shape the ways in which structural reforms play out. Thus there is considerable interplay between the formal and the informal structures that make up any system such as the NHS. The latest prescriptions from the Modernization Agency seem to recognize this[2].

However, much of the talk of culture in the NHS is rhetorical rather than substantive. Unpacking the concept can allow us to see clearly the scope and scale of the problems faced by health service reform, and may allow insights to be gleaned. If we move beyond rhetoric and ask some simple but searching questions (see Box 1) we should get a better idea of the cultural substrate that underpins service delivery. In addition, there now exists a range of tools that can be used to assess, both quantitatively and qualitatively, the prevailing cultures within organizations[9]. Thus there is scope for far more detailed and nuanced analysis of 'the cultural dimension' than we have seen hitherto.

Organizational culture, stressing as it does the informal unseen aspects of organizations, rightly gives the impression of something powerful, disruptive, dangerous even, lurking beneath the surface of any organization. As one US hospital group chief executive officer commented: 'Culture eats strategy for breakfast, every day, every time'. We need to understand such forces if healthcare organizations are to deliver to expectations in the 21st century.

Acknowledgments Of the many people with whom I have had helpful discussions around organizational culture, I especially thank Russell Mannion, Martin Marshall, Sandra Nutley, Tim Scott, Steve Shortell and Kieran Walshe.

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